# BEHAVIORAL HEALTH-HEALTH QUESTIONNAIRE

| San Luis Obispo Behavioral Health Department | ☐ DAS 2180 Johnson Ave, San Luis Obispo, CA 93401<br>Phone: (805) 781-4275 FAX( 805) 781-1227 | ☐ MH 2178 Johnson Ave, San Luis Obispo, CA 93401<br>Phone: (800) 838-1381 FAX (805) 781-1177 |
|---|---|---|

## Acuity Check List

☐No ☐Yes Do you have current, severe and/or untreated health problems?
☐No ☐Yes Are there any health concerns you currently have?
☐No ☐Yes Do you feel that you are at risk for hurting yourself or someone else?
☐No ☐Yes Are you being hurt by someone else or at risk of being hurt?
☐No ☐Yes Have you just used any form of drugs or alcohol? When:

## Medical Providers:

*Check any of the providers listed below you currently receive services from or have received from in the last 5 years.*

☐Community Health Center ☐Urgent Care Center ☐Dentists ☐Private Community Physician
☐Pain Management Services ☐Methadone Clinics ☐Hospital Emergency Rooms
☐Specialty Medicine (i.e. Immunization, Neurology, Cardiology, and Endocrinology)

## General Health Information

| 1. Date you last saw a doctor? | 2. What was the purpose of the visit? | 3. Date of your last physical? |
|---|---|---|

4.How many times have you visited an Emergency Room in the past 30 days?

5.How many days in past 30 have you stayed overnight in a hospital for physical health problems?

6.How many days in the past 30 have you experienced physical health problems?

7.Ever had surgery? ☐No ☐Yes If Yes please list major surgeries:

8.List any significant family medical history:

9.Are you able to perform activities of daily living: bathing, shopping, cleaning, use of transportation? ☐No ☐Yes

10.Do you have any religious, cultural, physical or other factors that might influence your care? ☐No ☐Yes-if yes please list:

11.History of any other illness that may require frequent medical attention? ☐No ☐Yes Give Details:

12. Allergic to anything? ☐No ☐Yes- If Yes fill out below

| ☐ Medications(list) | ☐Food (list) | ☐Other Specify |
|---|---|---|

13. **MEDICATIONS** List any prescription medications (including hormone replacement, birth control and psychiatric and/or anxiety meds) you are taking, include dosage and prescribing physician:_____

*What pharmacy do you use?*_____

*LIST OVER THE COUNTER MEDICATIONS YOU TAKE REGULARLY- Vitamins, food supplements or other meds such as Ibuprophen, Tylenol, Aspirin, Tums, Pepto Bismol, etc.*

**14. Are you currently experiencing any of the following**

| No Yes | No Yes | No Yes |
|---|---|---|
| ☐ ☐ Ankles Swollen | ☐ ☐ Jaundice-frequent yellowing of skin | ☐ ☐ Sinus problems |
| ☐ ☐ Bleeding problems, bruising easily | ☐ ☐ Joint pain or stiffness | ☐ ☐ Swallowing difficulty |
| ☐ ☐ Chest Pain (angina) | ☐ ☐ Excessive heartburn or abdominal pains? | ☐ ☐ Thirst-excessive |
| ☐ ☐ Cough; persistent or bloody | ☐ ☐ Chronic back pain | ☐ ☐ Tooth or gum problems |
| ☐ ☐ Diarrhea, constipation, Blood in stools | ☐ ☐ Nausea and vomiting | ☐ ☐ Urination frequent or bloody |
| ☐ ☐ Dizziness or fainting | ☐ ☐ Rashes | ☐ ☐ Vision-blurred or double vision |
| ☐ ☐ Fever | ☐ ☐ Seizures | ☐ ☐ Weight gain or loss recently |
| ☐ ☐ Headaches | ☐ ☐ Shortness of breath | |

**15. Do you have or have you had any of the following**

| No Yes | No Yes | No Yes |
|---|---|---|
| ☐ ☐ Arthritis | ☐ ☐ Anemia | ☐ ☐ High Blood Pressure |
| ☐ ☐ Artificial Joint | ☐ ☐ Blood Transfusions | ☐ ☐ Low Blood Pressure |
| ☐ ☐ Asthma, Emphysema or chronic bronchitis | ☐ ☐ Cancer | ☐ ☐ Stroke- If yes give details: |
| ☐ ☐ Diabetes | ☐ ☐ Chemotherapy/Radiation | |

16. No☐ Yes☐ Head injury resulting in loss of consciousness give details:

17. No☐ Yes☐ Heart Attack or Heart Problem-give details: Date of heart attack:

| CLIENT NAME | CLIENT NUMBER |
|---|---|

**18. Women Only**

| No | Yes | | No | Yes | |
|---|---|---|---|---|---|
| ☐ | ☐ | Are you pregnant? Due Date_____ | ☐ | ☐ | Any current or past domestic abuse? |
| ☐ | ☐ | Breast Feeding | ☐ | ☐ | Do you have pain with intercourse? |
| ☐ | ☐ | Have you had any miscarriages or abortions? | ☐ | ☐ | Abnormal mammogram or lump? Date:_____ |
| ☐ | ☐ | Do you have difficult periods? | ☐ | ☐ | Abnormal PAP? Date:_____ |

What age did you start your first period? _____

Date of last period: _____

Date of last GYN exam: _____

**Communicable Diseases**

19. ☐No ☐Yes Have you ever been tested for TB?

20. ☐No ☐Yes Have you ever had a positive TB Test? Date of last TB Test or last chest X-ray:

21. ☐No ☐Yes Have you been diagnosed with Hepatitis C? Date of last test: _____

22. ☐No ☐Yes Have you been tested for any other liver disease ? Specify:

23. ☐No ☐Yes Have you been diagnosed with a Sexually Transmitted Disease (STD)?

24. ☐No ☐Yes Did you get treated? Date of last STD test:

| 25. ☐No ☐Yes Been tested for HIV? | ☐No ☐Yes Did you receive the test result? | Date of last HIV Test: |
|---|---|---|

**Mental Health**

26. ☐No ☐Yes Have you ever been diagnosed with a mental illness? Were you treated? ☐No ☐Yes ☐Outpatient ☐Inpatient ☐NA
What was your diagnosis?

| | |
|---|---|
| 27. | How many times in the past 30 days have you received outpatient emergency services for mental health needs? |
| 28. | How many days in the past 30 days have you stayed 24 hours or more in a hospital or psychiatric facility for mental health needs? |

29. ☐No ☐Yes In the past 30 days, have you taken prescribed medication for mental health needs, *including medication for anxiety- list on question 13.*

| 30. Past suicide attempts? ☐No ☐Yes | Date of most recent attempt: | How many attempts in your lifetime? |
|---|---|---|

**Alcohol and Other Drugs**

31. Do you use any of the following substances and how frequently?
☐Alcohol ☐Currently ☐Sometimes ☐Never ☐Illicit Drugs ☐Currently ☐Sometimes ☐Never

Check all that apply

32. Have you ever injected drugs? ☐No ☐Yes If yes, check if you have ☐Shared needles? ☐Shared cottons?

| 33. How many days in the past 30 have you injected drugs? | Last time injecting: | Have you used SLO Co. Needle Exchange? |
|---|---|---|

34. Are you in withdrawal today? ☐No ☐Yes If Yes, from what substance(s)?

35. Seizures, delirium tremens? ☐No ☐Yes Date of last seizure:
If yes give details:

36. Do you have frequent blackouts? ☐No ☐Yes How frequently?

37. Are you currently smoking/ingesting marijuana? ☐No ☐Yes Medical Marijuana Card? ☐No ☐Yes
Date last smoked/ingested _____

38. Have you ever overdosed on alcohol or other drugs? ☐No ☐Yes If Yes on What? When?

**To the best of my knowledge the above information is accurate and true and I will inform my provider of changes in my health or medications:**
**Client Signature:** **Date:**

*******Staff Only Below*******

As the Medical Staff, I have reviewed this form and recommend the client:
- ☐ Receive a yearly physical exam that includes lab tests. Referral to Community Health Centers.
- ☐ Receive a TB test every year if at risk (been in jail, or other exposure).
- ☐ Needs Medical Evaluation before entrance to program
- ☐ HIV and or Hep C Test if at risk or for 6 month window
- ☐ Pregnancy Test ☐Prenatal Care
- ☐ CHC Dental Referral
- ☐Other_____
- ☐Counseled on signs/symptoms of withdrawal
- ☐Referred for Detox

Recommendations were provided to client:
- ☐ Discussed with client in person.
- ☐ Mailed to client (copy to chart).
- ☐ Given to clinician/staff to be discussed with client.
- ☐ **No additional referral needed at this time.**

**Medical Staff Signature:** **Date:**

**Clinician/Staff Signature:** **Date:**